ADVANCE DIRECTIVE FOR HEALTH CARE
CORRECT CARE SOLUTIONS
CONFIDENTIAL

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

I understand that there may come a time when I am in a condition wherein I cannot express my wishes about medical treatments. Because this might happen, I now want to indicate which treatments I want and which treatments I don't want.

If I have a condition wherein my doctors believe that there is little hope that I will recover and that my death is likely no matter what is done, then I request that this document indicate my choices about the following medical treatments: (*please mark appropriate boxes below*).

	WANT	DON'T WANT
CARDIOPULMONARY RESUSCITATION (CPR) – the use of drugs, artificial breathing, and electric shock to start the heart beating.	☐	☐
MECHANICAL BREATHING – breathing by a machine through a tube placed in the airway.	☐	☐
SURGERY – such as removing the gallbladder or part of the intestines.	☐	☐
INVASIVE TESTS – such as using a flexible tube to look into the stomach or lungs.	☐	☐
NUTRITION AND HYDRATION – food and fluid given through a tube in the veins, nose, or stomach.	☐	☐
TRANSFUSION – of blood or blood products such as platelets or plasma.	☐	☐
ANTIBIOTICS – drugs to fight infection.	☐	☐
NON-INVASIVE TESTS – tests with little potential for complications and discomfort, such as blood tests or x-rays.	☐	☐
OTHER – _____	☐	☐
_____	☐	☐

I, _____, make this advance directive for health care to indicate my wishes about medical treatment in the event that I become unable to communicate them directly. I am at least 18 years of age, of sound mind, and I understand the consequences of my decisions.

_____ _____

Signature of inmate — Date (*month, day, year*)

_____ _____

Signature of witness — Date (*month, day, year*)

_____ _____

I have reviewed this document with the patient on (*date*) — Signature of Practitioner

D25D7DP45177PNXN

Hunger Strike Contacts and Comments

CCS CORRECT CARE SOLUTIONS

Patient Name	*Patient Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Site Hunger Strike Information (contacts and interventions – include mental health, general physical health, chaplain, family, court, and so on; also include team meetings and other activities with impact on the hunger strike)

Name, credential, or relationship, or nature of occurrence	Date	Describe what happened

Hunger Strike Initial Information

CCS CORRECT CARE SOLUTIONS

Patient Name	*Patient Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Identifying Information

Inmate name and number	Facility	Housing area	Stated reason for hunger strike	Previous hunger strikes?
Date started	Date identified	Date CCE sent		

Previous medical history (include height and weight)	Ideal body weight and .8 IBW

Previous mental health history

Current medications

Other initial observations

Objective observations

Date and time	Weight	Urine specific gravity	BP supine	P supine	BP upright	P upright	Na, K	BUN, Crt	Comment

Hunger Strike Initial Information

CCS CORRECT CARE SOLUTIONS

Patient Name	Patient Number	Booking Number	Date of Birth	Today's Date

Objective observations continuation page

Date and time	Weight	Urine specific gravity	BP supine	P supine	BP upright	P upright	Na, K	BUN, Crt	Comment

D13541DP43382PNXN

MEDICAL SERVICES
FOOD AND VITAL SIGN MONITORING HUNGER STRIKE

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

_____
Site

DATE/TIME MEDICAL NOTIFIED: _____

DATE/TIME LAST FOOD INTAKE: _____DATE/TIME LAST WATER INTAKE: _____

INITIAL VITAL SIGNS: T ___ P ____ R ____ B/P (lying) ___/____ B/P (standing) ___/____ WT ___ HT ____

DAILY EVALUATION:

DATE/TIME	WEIGHT	BP SUPINE	PULSE	BP STAND	PULSE	URINE KETONES	ACTIVITY LEVEL	SIGNATURE

FOOD/WATER OFFERED:

DATE/TIME	TYPE OFFERED	AMT. INTAKE	INITIALS

DATE/TIME	TYPE OFFERED	AMT. INTAKE	INITIALS

MEDICAL STAFF SIGNATURE _____ DATE/TIME: _____

D2508DP59010PNXN

MEDICAL CLEARANCE FORM

For Inmate Workers

CCS CORRECT CARE SOLUTIONS

Patient Name	*Patient Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Date of Last Physical: _____ Date of Last TB Test: _____

☐ No ☐ Yes History of Positive TB Skin Test?
☐ No ☐ Yes Cuts noted on hands, arms, face or neck?
☐ No ☐ Yes Open sores or rash noted on hands, arms, face or neck?
☐ No ☐ Yes Recent diarrhea, loose, or watery stools?
☐ No ☐ Yes Recent nausea and/or vomiting?
☐ No ☐ Yes Recent abdominal cramping?
☐ No ☐ Yes Back problems?
☐ No ☐ Yes Presently being treated for a chronic illness?
☐ No ☐ Yes Being treated for seizures?
☐ No ☐ Yes Shows any obvious signs of any other disease?
☐ No ☐ Yes Restrictions to activity? _____
☐ No ☐ Yes Takes medication that make them drowsy or dizzy?

_____ This patient has been examined by health care staff for consideration as an Inmate Worker

_____ This patient has no history or current complaints of contagious diseases.

Patient has been: ☐ **Approved** ☐ **Approved with noted limitations:** ☐ **Denied**

_____

_____

☐ **Approved as Food Service Worker**

This Patient has been informed of the need for the following:

- ☐ Daily showers
- ☐ Proper hand washing prior to handling food and after using the restroom.
- ☐ Fingernails are to be kept clean and neat
- ☐ Clean hair, must be worn under hairnet
- ☐ Not to handle food while sick
- ☐ Notify Dietary Services Shift Supervisor of any illness
- ☐ When ill, submit a sick call slip for a medical evaluation
- ☐ Screening for Medical Clearance will be done annually

I have been educated to the health instructions above and agree to comply with the directions should I be assigned to Work Release, Hall, Kitchen, or other Trustee duties. To the best of my knowledge I have no physical or mental limitations preventing me from doing the jobs required for Inmate Worker Status. **If assigned to Kitchen duty, I also agree <u>not</u> to handle food while sick, seek medical evaluation when necessary and to notify the Dietary Services Shift Supervisor of any illness.**

_____ _____
Patient Signature Date

_____ _____
Health Care Staff Signature Date

This clearance is good for one (1) year or if revoked due to a medical problem preventing Inmate Worker from performing duties as assigned.

Vermont Department of Corrections
MEDICAL DIET FORM

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

PID #_____ Unit:_____ Date:_____

Start Date:_____ Expiration Date:_____
(only Verified Allergies can be written indefinitely)

(Check one) { } New { }Renewal { }Cancel

Formulary Diets

{ }Clear Liquid (Broths & Pulpless Juice, Jello)
{ }Pureed (for transition from liquid to soft)
{ }Soft Diet (for post surgery with low food tolerance)
{ }Mechanical Soft (Chopped by hand, Not blended)
(no hard, crunchy or nuts/ground meats, canned or well cooked fruits & Veg.)
{ }N.P.O. Nothing by Mouth
{ }Renal: Consult Required

Diabetic & Weight Loss { }AM,{ }PM
{ }200 kcal Snack
{ }1500 kcal ADA
{ }1800 kcal ADA
{ }2200 kcal ADA Heart Healthy
Also Used For:
Low Fat/Low Cholesterol, Low Saturated Fat <10%, Balanced Sodium<3000mg, High Fiber>25g, Pregnancy & Lactation

{ }Allergies-Specific Food(s): _____

{ }Not Verified-14 days to verify Written by:

{ }Verified-Indefinite Verified by:

Non-Formulary Diets-RMD approval attachment required

Nutritional Objective:	
Medications:	
Height & Weight/BMI:	Mental Health Involved { }

Qualified Health Care Initial Review: { }Approval Date:_____

Per Qualified Medical Provider (Print):_____

(Sign):_____ MD, PA, APRN ,NP, WHNP

90 Day Review Date:_____ Diet Continued: { }Yes { }No
(Date of review)

(Print Name and Sign):_____

Next Review Date: _____

CC:Food Service Supervisor, Inmate, Asst. Superintendent, Medical Department, Original to Medical File

Rev. June 2010

D127462DP25689PN1N

Vermont Department of Corrections
MEDICAL DIET FORM

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

VERMONT DEPARTMENT OF CORRECTIONS
SERVICE AGREEMENT FOR MEDICAL/NUTRITIONAL THERAPY

TO THE INMATE:

1. The Medical Diet:
- This is recommended as a part of your medical/nutritional treatment plan.
- At this time you have the right to refuse this treatment.
- In the future, through a written request to a qualified health care professional, you have the right to refuse your medical diet.

2. At Meal Service:
- You are required to follow the procedure as outlined by the Food Services Staff for receiving your medical diet during mealtimes.
- You are responsible for checking your tray for mistakes and reporting this to the Food Services Officer immediately.

3. Non-compliance of your Medical Diet is:
- Failure to pick up four (4) meals within a one (1) month period.
- Observations by the Food Services Staff that the diet is not being used properly; for example, selling food items from your medical tray.
- Observation that you were taking food from the regular line, or from other inmates in addition to, or in place of, your medical diet tray.
- Making Commissary purchases contrary to the foods included on your medical diet.

4. Discontinuance of the Medical Diet:
- Your medical record will contain at least one (1) note stating that you have been counseled regarding the need for the medical diet.
- Your failure to comply with the medical diet will result in diet discontinuance.
- You can notify the qualified health care professional in writing if you are requesting to cancel your medically-prescribed diet.
- If you take a regular diet tray instead of your medical diet tray, this may result in a cancellation of the medical diet.

5. Reinstatement of the Medical Diet:
- You must make an appointment to see the qualified health care professional to discuss reinstating your medical diet.
- The qualified health care professional will make the decision whether to reinstate the medical diet; this may include the decision to reinstate it for one (1) time only.

I understand the above information provided to me regarding my medical diet. (*Check one line below and sign this form.*)

_____ I *accept* the medical diet and will abide by the stated rules.

_____ I *refuse* the prescribed medical diet at this time. I reserve the right to reconsider at a later date and will make an appointment to see the qualified health care professional at that time.

Inmate Name: _____ *Inmate Signature*: _____
DOB: _____ Date: _____

Qualified Health Care Professional (*Name*):_____ *Signature*: _____
Date: _____

Cc: Food Services Supervisor, Assistant Superintendent, Medical Department, Inmate Medical File, Inmate

D12746DP25689PN1N

NPO Instructions

Patient Name	Inmate Number	Booking Number	Date of Birth	Today's Date

NPO INSTRUCTIONS
INSTRUCCIONES DE NO INGERIR (NPO por sus siglas en inglés)

NPO Education / Instrucciones de NPO:

Patient instructed to be NPO after midnight tonight. It was explained to the patient that "NPO" means no eating or drinking of fluids or ice cubes. Patient instructed to be NPO until the procedure is completed. The importance and rationale of being NPO was explained (for example, decreased risk of aspiration, death, or the postponement of the procedure).

Se les indicó a los pacientes permanecer en estado NPO a partir de la medianoche de hoy. Se les explicó a los pacientes que "NPO" significa que no deben comer ni beber líquido o cubos de hielo. Se indicó que los pacientes deben permanecer en estado "NPO" hasta que finalice el procedimiento. Se explicó la importancia y el motivo de NPO (por ejemplo, disminución del riesgo de aspiración, muerte o la postergación del procedimiento).

NPO Statement of Understanding / Declaración de haber entendido lo que es NPO:

I _____ have been instructed to have nothing by mouth after midnight tonight (NPO). This includes food, drink, water, ice cubes, etc. I may have nothing other than small sips of water with medication until after my procedure.

If I do not follow these directions, this may result in the postponement of my procedure or I may be injured by anesthetic or the procedure and may experience permanent injury or death.

Yo _____ recibí las instrucciones de no ingerir nada por la boca a partir de la medianoche de hoy (NPO). Esto incluye comida, bebida, agua, cubos de hielo, etc. No puedo ingerir nada, excepto pequeños sorbos de agua con la medicina hasta que finalice mi procedimiento.

Si no cumplo con estas indicaciones, mi procedimiento se puede postergar o la anestesia o el procedimiento puede causar lesiones en mí y puedo experimentar lesiones permanentes y hasta la muerte.

I agree to this / Acuerdo hacerlo:

_____ _____

Patient Signature / Firma del paciente — Date / Fecha

_____ _____

Medical Staff Signature — Date

(Not to be given to resident prior to night lockdown.)

Patient Prescription Eligibility Form

Patient Name	Patient Number	Booking Number	Date of Birth	Today's Date

Gender ☐M ☐F Release Date**:_____ Facility Fax: _____

_____
Member ID #*

*Member ID =
3 digit site code + up to 15 digit Patient ID#

Prescription Processing Information
Processor: Prescription Solutions (**PRSOL**)
CVS Condor Code: **7114**
Group #: **CCS** _____
Bin: **610494**
PCN: **9999**

List Release Medications Below that are to be covered	**DISPENSE GENERIC ONLY** (UNLESS DISPENSE AS WRITTEN)	
Drug Name and Strength (with sig / directions)	***Indication***	***Days Supply***

FAX THIS FORM TO InMedRx @ 1-888-363-1013 ◆ TOLL FREE PHONE NUMBER: 1-888-896-1283

Authorized Signature: _____ Telephone # _____ Date: _____

Attention Pharmacist: *The Member Listed above is currently eligible for benefits under this prescription care plan. Medications on this plan require Prior Authorization. The Patient ID # and prescription processing information is located at the top of the page. All medications may or may not be covered at the discretion of the sponsor and eligibility can be discontinued at any time at the discretion of the sponsor. For questions or problems processing claims for this patient, please call the InMedRx staff 24/7/365 at* ***888-896-1283****.*

****Eligibility is valid for 72 hours from Date of Release noted above***

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Pre-segregation Health Evaluation

(Two page pathway)

CCS CORRECT CARE SOLUTIONS

Patient Name	Inmate Number	Date of Birth	Today's Date

MEDICAL HISTORY:

ALLERGIES: _____ CURRENTLY TAKING MEDS: ☐YES ☐NO

HOLDS: ☐MEDICAL ☐PSYCH RECENT SAFE ROOM PLACEMENTS: ☐YES ☐NO

If YES, Then Date of last placement per JMS _____

MEDICAL PROBLEMS: _____

PSYCH PROBLEMS: _____

WEIGHT: _____ TEMP: _____ PULSE: _____ BLOOD PRESSURE: _____ RESP: _____

CHECK APPROPRIATE RESPONSE BOXES BELOW

PHYSICAL ASSESSMENT AND OBSERVATION:

General Appearance ☐Clean ☐Neat ☐Dirty ☐Disheveled

SKIN

1. Turgor ☐ Non-tenting ☐ Tenting
2. Lacerations ☐ Yes ☐ No
3. Bruising ☐Yes ☐ No
4. ☐Not Assessed

RESPIRATORY

1. Breath Sounds ☐ CTAB ☐ Abnormal
2. Dyspnea ☐ Yes ☐ No
3. Cyanosis ☐ Yes ☐ No
4. ☐ Not Assessed

MUSCULOSKELETAL

1. Upper Extremities ROM ☐ WNL ☐ Abnormal
2. Lower Extremities ROM ☐WNL ☐Abnormal
3. ☐Not Assessed

NEUROLOGICAL

1. Headache/Dizziness ☐Yes ☐ No
2. Speech ☐Fluent ☐Slurred
3. Pupils ___ mm ☐ PERLA ☐ Abnormal
4. ☐Not Assessed

CARDIOVASCULAR

1. Rhythm ☐ Regular ☐ Abnormal
2. Pedal Edema ☐ Yes +___ ☐ No
3. Chest Pain ☐ Yes ☐ No
4. ☐ Not Assessed

GI/GU

1. BS x4 ☐ Yes ☐ No
2. Distension ☐ Yes ☐ No
3. N/V/D ☐ Yes ☐ No
4. Abdominal Pain ☐ Yes ☐ No
5. Dysuria ☐ Yes ☐ No
6. Flank Pain ☐ Yes ☐ No
7. Discharge ☐ Yes ☐ No
8. ☐Not Assessed

PSYCHIATRIC RISK ASSESSMENT

1. Currently experiencing suicidal thoughts or thoughts of self harm? ☐ Yes ☐ No
   (if YES, place immediate phone call to mental health)
2. Past history of suicide attempts? ☐ Yes ☐ No
3. Recently seen by mental health professional ☐ Yes ☐ No
   (Check PEARL and ask pt)
4. Recent Safe Room placement ☐ Yes ☐ No
5. Orientation ☐Person ☐Place ☐Time
6. Does the patient exhibit any sort of disorganized, paranoid or illogical thoughts? ☐Yes ☐ No
7. Does the patient seem to be behaving in an appropriate manner during interview? ☐Yes ☐ No
8. Has the patient recently experienced a traumatic event? (Ie—informed of the death of a loved one; received lengthy sentence) ☐ Yes ☐No

Clear for segregation placement ☐ Yes ☐ No Referred: ☐ Yes ☐ No If yes: ☐Mental Health ☐ HCP

Examiner: _____

Date/Time: _____

Pre-segregation Health Evaluation

(Two page pathway)

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Date of Birth*	*Today's Date*

COMMENTS REQUIRED ON ALL ABNORMALITIES:

Examiner:_____

Date/Time: _____

Segregation
Inmate Daily Assessment Form

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Date Assigned:_____ Assigned By: ☐ Correctional Personnel
☐ Health Personnel

Date Released:_____ SFI ___ Refer to Mental Health ____

Note: Health staff will initiate observation rounds on the day the inmate is placed in segregation. Inmates placed in segregation will have their vital signs checked weekly.

Observation Frequency: ☐ Daily ☐ _____Times per week

Day	Date	Time	Observations/Notes/Condition	Signature
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Physical Date:	WT:	BP:	Pulse: Resp:	Temp:
Sunday				
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Physical Date:	WT:	BP:	Pulse: Resp:	Temp:

revised 05/01/2010

D2930DP4504 1PNXN

1

Segregation Record Review and Visit Log

CCS CORRECT CARE SOLUTIONS

Patient Name	*Inmate Number*	*Booking Number*	*Date of Birth*	*Today's Date*

Date Notified: Time Notified:

Existing medical conditions precluding housing in segregation: ☐ No ☐ Yes If Yes, describe:	Security notified: ☐ Not indicated ☐ Yes Date: Time:
Currently receiving mental health services: ☐ No ☐ Yes	Mental Health notified of admission to segregation: ☐ Not Indicated ☐ Yes Date: Time:
Currently on medications: ☐ No ☐ Yes	Arrangements made for medication administration: ☐ Not indicated ☐ Yes

Signature _____ Date _____ Time _____ Housing Unit : _____

Visit Log

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
January																															
February																															
March																															
April																															
May																															
June																															
July																															
August																															
September																															
October																															
November																															
December																															

Nurses Sign & Initial: _____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

D179960P31446PNXN

THE EFFECTS OF STARVATION

CCS CORRECT CARE SOLUTIONS

Patient Name	Patient Number	Booking Number	Date of Birth	Today's Date

Prolonged starvation can result in serious harm to a person's body and mind. When a person's caloric intake falls far below his daily energy expenditure, a complex series of reactions are set in motion by the body in an effort to defend items against this abnormal condition. These reactions go far beyond a simple loss of weight and an emaciated appearance. If these reactions are prolonged as severe enough, they can result in serious damage or death.

When there is a deficit in energy intake, the body draws on its stores to maintain blood glucose, it's main fuel. The body will first use whatever stored fat may be available. When fat stores are exhausted, the body will then begin to use muscle and organ tissue to produce energy. As this occurs, there is a wasting away of muscle and of tissue in the liver and intestines, and the heart decreases in size and output. Blood pressure and respiratory rates are reduced and cardio-respiratory failure can eventually occur. The skin becomes thin, dry, inelastic, pale and cold and bones protrude. A patchy brown pigmentation may occur. Hair becomes dry and sparse and falls out easily. There is a loss of sex drive. Diarrhea may occur and hasten the wasting process. Apathy and irritability are common. Eventually the body enters a comatose state, usually followed by death.

Proteins are essential for maintenance of cellular functions and when the body's proteins have been depleted to approximately one-half of their normal levels, death ordinarily ensues.

In addition to the above factors, many negative changes in the chemistry of the body also occur. Vitamin deficiencies occur (particularly in the Vitamin B group and Vitamin C) and further weaken the body. Resistance to disease and infections decreases, making the body vulnerable to other illnesses.

I understand that my refusal to eat can bring about the above detrimental effects (as well as others) on my body and my well being. I understand that continued refusal to eat may result in serious and possibly irreversible bodily changes and can eventually result in my death. Furthermore, I understand that the Facility will do everything within its power to prevent the death of any person committed to its custody.

I hereby certify that I have read (or had read to me) and had explained to me the destructive effects that occur to my body as a result of my refusal to eat.

PATIENT NAME	SIGNATURE	DATE
WITNESS	SIGNATURE	DATE

Patient _____ Inmate # _____ has been advised of the above information regarding the deterioration effects of his continued refusal to eat by

_____ on _____ but refused to sign the above form.
(name) (date)

CCS HEALTHCARE WITNESS	SIGNATURE	DATE
WITNESS	SIGNATURE	DATE

D2509DP22900PNXN

LOS EFECTOS DE LA INANICIÓN (RECHAZO A LA COMIDA)
THE EFFECTS OF STARVATION

CCS CORRECT CARE SOLUTIONS

Patient Name	Patient Number	Booking Number	Date of Birth	Today's Date

La inanición prolongada puede causar daños serios en el cuerpo y en la mente de una persona. Cuando el consumo de calorías de una persona se encuentra muy por debajo de la energía de uso diario, el cuerpo activa una serie de reacciones complejas con el fin de defenderse contra esta condición anormal. Estas reacciones van más allá de una simple pérdida de peso y una apariencia demacrada. Si estas reacciones son prolongadas y lo suficientemente graves, pueden causar daños serios y hasta la muerte.

Cuando existe la falta de consumo de energía, el cuerpo recurre a sus almacenamientos para mantener la glucosa sanguínea, su principal combustible. El cuerpo primero utilizará las grasas disponibles almacenadas. Cuando se acaben las reservas de grasa, el cuerpo comenzará a utilizar los tejidos de los músculos y los órganos para producir energía. Cuando ocurre esto, existe una pérdida de músculo y de tejido en el hígado y los intestinos y el corazón disminuye su tamaño y producción. La presión sanguínea y el ritmo respiratorio se reducen y puede ocurrir una falla cardio-respiratoria. La piel comienza a ser más fina, seca, menos elástica, pálida y fría y los huesos comienzan a sobresalir. Puede ocurrir una pigmentación marrón irregular. El cabello se vuelve más seco y escaso y se cae fácilmente. Disminuye el apetito sexual. Puede ocurrir diarrea y esto acelera el proceso de pérdida de peso. La apatía y la irritabilidad se convierten en estados comunes. Finalmente, el cuerpo entra en un estado de coma que por lo general es seguido por la muerte.

Las proteínas son esenciales para el mantenimiento de las funciones celulares y cuando se han reducido drásticamente las proteínas del cuerpo aproximadamente la mitad de sus niveles normales, normalmente sucede la muerte.

Además de los factores mencionados anteriormente, también ocurren muchos cambios negativos en la química del cuerpo Ocurre la falta de vitaminas (particularmente Vitamina B y Vitamina C) y esto debilita aún más el cuerpo. La resistencia contra las enfermedades y las infecciones disminuye, esto hace que el cuerpo sea más vulnerable a otras enfermedades.

Entiendo que mi rechazo a comer puede provocar los efectos perjudiciales mencionados anteriormente (como así también otros) en mi cuerpo y en mi bienestar. Comprendo que el rechazo continuo a comer puede causar cambios corporales serios y, posiblemente, irreversibles y que eventualmente puede causar mi muerte. Además, entiendo que la Institución hará todo lo posible para evitar la muerte de cualquier persona bajo su tutela.
Por la presente certifico que he leído (o me han leído) y me han explicado los efectos destructivos que puede sufrir mi cuerpo como resultado de mi rechazo a comer.

NOMBRE DEL PACIENTE / PATIENT NAME _____ FIRMA / SIGNATURE _____ FECHA

TESTIGO / WITNESS _____ FIRMA / SIGNATURE _____ FECHA

Patient _____ Inmate # _____ has been advised of the above information regarding the deterioration effects of his continued refusal to eat by

_____ on _____ but refused to sign the above form.
(name) (date)

CCS HEALTHCARE WITNESS _____ SIGNATURE _____ DATE

WITNESS _____ SIGNATURE _____ DATE

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